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ABSTRACT

This paper discusses the ineffectiveness of Suicide Prevention Centers in terms of the following: (1) diffusion vs. specific focus; (2) client centered orientation; (3) passive approach, and (4) failure to develop minority programs. Suggestions for improving prevention efforts are presented. (JLL)

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WHY SUICIDE PREVENTION CENTERS DON'T WORK

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If the purpose of Suicide Prevention Centers in America is to reduce suicide rates, then few among even the most highly dedicated proponents of these Centers would claim that this goal has been accomplished. Fewer still would assert for Suicide Prevention Centers the effectiveness attributed to similar public health agencies such as VD Clinics, Planned Parenthood, or well-baby clinics. Even suicidologists themselves have difficulty in finding data which substantiates the effectiveness of their work. Farberow (1970), in a ten year review of the suicide prevention movement, suggested strategies for evaluating effectiveness but did not provide citations. In the same journal, Litman (1970) wrote, "The fact that the suicide rate in Los Angeles declined from 178 in 1962 to 150 in 1967 has no necessary relationship with the fact that the number of suicide prevention service cases increased from 1,000 to 7,000 a year during the same period of time."

There are, without doubt, major methodological problems associated with demonstrating that SPC's reduce suicide. Where the independent variable has major impact on the phenomena under study, such as the impact of the Salk polio vaccine on the incidence of poliomyelitis, methodological problems are minimized. Where the impact of the independent variable is quite subtle, methodological problems can be excruciating.

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In an age when every modern manager ties work effort to goal achievement, how do we come to spend so many years, devote so many thousands of hours to a venture wherein the payoff in averted suicide is so uncertain? An impartial observer of this activity could speculate that those engaged in suicide prevention work may well fulfill goals other than those described by the suicide prevention label. These collateral goals might include satisfaction of intellectual curiosity, the development of professional status and prestige, socialization, or perhaps just the simple goal of locating one's self on the "right" side of the counseling desk. Further study of this issue would help to explain the remarkably stable "functional autonomy" of Suicide Prevention Centers. However, before wandering too far from our main topic, let us return to the question of "Why Suicide Prevention Centers Don't Work."

I. Diffusion vs. Specific Focus

Suicide Prevention Centers offer their activities to the entire community which they serve. This global approach may undermine the efficient targeting of the most lethal segments of the population because suicide is highly specific to certain segments of the population.

In a recent article, one of many which illustrate this point, DeGrove (1977) analyzed the contribution of several core variables to White suicide rates in 24 Florida counties. He developed a prediction equation which accounted for 79% of the variation in suicide rates in these counties based on the variables of age, crime rate, insanity and alcoholism.

It would be encouraging to report that following publication of DeGrove's findings a crisis ensued in Suicide Prevention Centers in America; a crisis which was resolved by major programmatic efforts to tailor programs specifically to the high risk populations pinpointed by this new data. But nothing of the sort has occurred. We just keep on promoting our services to the population at large in the apparently vain hope that over time, these efforts will bear fruit.

Can it be that a genuine response to DeGrove's article would bring us into major conflict with other segments of the mental health movement - that we would be forced to tell many CCMHC's that some of their activities promote suicide among their clientele, that we would be required to identify another allegedly positive force in society, the criminal justice system, as a set of agencies whose activities contribute substantially to premature death among our young people? Articles such as DeGrove's have not substantially influenced the suicide prevention movement.

II. Client Centered Orientation

Suicide Prevention Centers have been client oriented and have neglected other variables in the suicide environment. A prevention strategy directed wholly to the suicidal person neglects other contributing variables such as social factors which provide the suicide with his instruments, and with his environment for suicide.

Although the two major methods of suicide consist of ingestion and handguns, neither Suicide Prevention Centers nor the National Association have been particularly active in attempts

to modify the access of suicidal persons to these lethal means.

Up until this year, I never met or heard of a pharmacist attending a suicide prevention conference, yet through the hands of these colleagues flow the pills which constitute the means of most suicide attempts and an extraordinary number of completed suicides as well. I am not going to belabor an obvious point but several constructive suggestions can be offered: i.e. pharmacists can be trained to detect lethality in customers who purchase dangerous medication; modern data processing methods can be applied to prevent suicidal patients' misuse of medical services; and communication between pharmacists and SPC workers can be improved.

Many of the considerations applied to pharmacists apply equally to purveyors of firearms. Certainly the numbers of suicides that occur just after the victim has purchased a handgun are legion. Since we do not seem to be doing at all well with efforts to control the sale and distribution of firearms, perhaps some changes can be made in the behavior of the salesman. Can suicidal buyers be identified by handgun salesmen? If so, what techniques can be employed to train these gatekeepers to reach out to potential suicides in a constructive way.

III. Suicide Prevention Centers Are Passive

The prodigious capacity of suicidal persons for evading or refusing offers of help is well known. The suicidal person feels helpless, immobilized, and is often quite passive. The more active members of the suicidal population are the individuals who generate the drive to seek out help, as for example, through

telephone requests. Indeed, it has been contended that Suicide Prevention Centers reach the least lethal segments of the suicidal population.

Welu (1977), Selkin and Braucht (1976), and others have reported positive findings in their studies of outreach programs designed to locate suicidal persons in the community and visit them in their homes. Outreach programs may offer a more effective approach to suicide prevention than our current approach which essentially consists of waiting for the telephone to ring. But more active approaches may outstrip the resources of many of our Centers by increasing demands on volunteers and on Center budgets as well. Nevertheless, the movement as a whole has not developed active outreach programs for providing services to those in greatest need, alcoholics, mental patients, aged, and delinquent populations.

This failure to develop outreach programs where relevant, along with our failure to react vigorously to research findings, provides substantiation for the assertion that the Suicide Prevention Center is passively oriented. Limited capacity to respond to community needs in the area of suicide prevention has been demonstrated. I think that the passive approach to prevention is closely related to the dominant role of volunteers in the movement. The SPC movement consists largely of middle class telephone counselors whose goal is to provide telephone counseling services to people who feel suicidal and further, feel like making a phone call. Volunteers are usually persons with a limited commitment to the work and they are reluctant to

undertake new activities for which they have not volunteered, however useful such efforts might be.

IV. Failure to Develop Minority Programs

We hear almost daily about the alarming increases in suicide among minorities, especially minority youth. What are we doing about it? Again the passive mode of the typical Suicide Prevention Center, the absence of any but white middle class staff and volunteers, the location of Centers in commercial or residential areas populated by Anglos, all combine to effectively cut off services to yet one more high suicidal segment of the population

Suggestions for Radical Changes

Our suggestions for change are inherent in the criticisms of the movement as it presently functions. Suicide Prevention Centers need to utilize research findings and focus their efforts on suicidal populations. Active programs need to be developed that will enable us to penetrate social systems in which a high rate of suicide is an integral and accepted component. Efforts must be generated to contact the gatekeepers of suicidal equipment such as pills and handguns. New programs for training these gatekeepers in suicide prevention should be attempted.

My call is for a massive re-evaluation of the SPC movement. Reorganization is necessary in order to closely tie goals to means. Incorporation of many new professional and commercial groups is indicated. Utilization of current research in daily practice is essential. We must look at the past thirty years

as a beginning, and at the years to come as an opportunity to pursue our efforts with steadily increasing success.

REFERENCES

DeGrove, W. An assessment of community suicide risk. Suicide and Life Threatening Behavior, 1977, 7(2), 100-110.

Farberow, N. Ten years of suicide prevention. Bulletin of Suicidology, Spring 1970, 6, 6-12.

Litman, R. Suicide prevention center patients: a follow-up study. Bulletin of Suicidology, Spring 1970, 6, 12-18.

Selkin, J. & Braucht, G. N. Home treatment of suicidal persons. Chapter in Crisis and Disaster Management. Ed. by Parad, L., Resnik, H., & Parad, H. Bowie, Maryland: Robert J. Brady (Prentice-Hall), 1976, 45-53.

Welu, T. C. A follow-up program for suicide attempters: evaluation of effectiveness. Suicide and Life Threatening Behavior, Spring 1977, 7(1), 17-31.